Appendix 22a ▪ Instructions for Care Plan

The care plan document must be completed fully and accurately for each MSSP client. The sites may modify the care plan form; however, the basic integrity and all components of the form must be maintained with space allotted to record the required information. The care plan document must include the following components:

A. Client name
Enter the client's first and last name.

B. MSSP #
Enter the client's assigned MSSP #.

C. Dates

1. Care Plan Conference Date

   Enter the date the care plan conference took place.

2. Duration of Care Plan

   The duration of the care plan is twelve months beginning with the month of enrollment. (e.g., a client enrolled in February 2012 has a care plan duration date of February 2012 – February 2013. **Month and year are required components; day is optional.** A client enrolled April 5, 2011 has a care plan duration date of April 5, 2011 – April 30, 2012).

3. Date (1st column)

   Enter the date the problem or issue was originally identified or reconfirmed.

D. Problem #
The "Problem #" section will list client problem statements numerically in a sequential manner. The care plan problem statement numbers remain the same as long as the problem statement is active. Retired problem statement numbers can be reactivated due to recurrence.

Problem statements may be renumbered starting with "1" if the care plan is completely rewritten during the month of reassessment. Care managers must document in the progress notes what has happened to old care plan problem statements, e.g., whether the problem statements have been combined into a new problem statement or resolved. This information can also be documented on the care plan form under the "date resolved/comments" column.

NOTE: Many problem statements remain active as long as the client is enrolled in MSSP. Providing and/or discontinuing interventions will not always result in the need for/or resolution of problem statements.

E. Problem Statements

1. Problem statements are derived from areas of concern identified in the re/assessments for which specific services and/or care management activities are provided.

2. Problem statements must address specific needs and include the client's functional deficits.

3. Description of a client's functional deficit can include the medical diagnoses in problem statements. The client's medical diagnoses alone may not define the problem statement or substantiate the need for services.

4. In addition to the functional deficit the problem statement should include reference to the impact on the client (what is the risk to the client or how is this a problem for the client?).

5. Whenever new problems are identified, they must be added to the care plan. They may be handwritten on the existing care plan and do not require a new client signature.

6. The problem statements identified on the care plan must:

    a. Justify the need for care management.

    b. Substantiate the need for service delivery, including informal, referred, and purchased services.

    c. Reflect the multi-disciplinary team collaboration on assessment findings. Problems not identified prior to the conference should be added at the care planning conference.

7. If problem areas have been identified that will not be addressed in the care plan, an explanation must be documented in the progress notes.

F. Client Goal/Outcome

- Goals must be measurable, reflect the client's input and consider the client's preferences.

- Measurable goals must describe outcomes and/or achievements that pertain to problem statements.

- Goals specify the skills to be acquired, behaviors to be changed, information to be provided, health or psychosocial conditions to be met.

G. Service Provider Name and Type

The Service Provider and Type section will list the service provider for all services. The type of provider(s) for each service will also be entered (Section 3.930, Authorization and Utilization of Services):

I = Informal: a service provided without cost through the client's network of family, friends, or other informal helpers.

R = Referred: a service provided without cost through referral to a formal organized program or agency (e.g., Meals on Wheels, transportation funded by Title IIIB, etc.).

P = Purchased: a service or item purchased with waiver service funds.

C = Care Management is the coordination of care and services provided to facilitate appropriate delivery of care and services.

More than one vendor/provider and/or provider type may be entered for an individual service.

For purchased services/items using Waiver Service funds, the site should enter the name of the provider if known. A generic entry for a vendor (Building Supply Store) or specific name (Home Depot) can be made on the Care Plan. Once a purchase is made, the name of the vendor and item(s) and/or service(s) purchased must be documented in the Progress Notes and on the SPUS. The provider information may also be added (handwritten or electronically) to the Care Plan.

Note: If the provider is listed on the care plan in generic format or as a projected vendor, clarification on the care plan is not required. The point of purchase must be on the SPUS and in the Progress Notes. All interventions must be on the SPUS and on the care plan. The information may be handwritten or entered electronically when known or at the time of purchase.

H. Plan/Intervention

The Plan/Intervention section lists information pertinent to problem statements and outlines possible actions, items to be provided, plans, or solutions to address the problem statements. Interventions that have the greatest probability of success are those that consider the client's preferences, perception of the problem or situation, and are compatible with the client's beliefs, values, and attitudes. The services and/or items may be in a format specified by the site (list; narrative).

It is acceptable to enter a generic category of services/items as an intervention (e.g. incontinence supplies) at the onset. Once specific services/items are purchased (e.g. gloves & wipes) a notation must be entered on the Care Plan (handwritten or electronically) defining all services and items purchased using Waiver Service funds. When a new issue arises, the existing problem statements should be evaluated to determine whether the new intervention(s) can be added. The addition of an intervention may be handwritten or entered electronically on the Care Plan. This does not require the client's signature.

All interventions must be listed on the Care Plan. Failure to record an intervention on the Care Plan could result in recovery of funds.

I. Date Resolved/Comments

This section documents the result to be obtained from interventions provided.

- Comments include information regarding the results of care management interventions; (e.g., when an item was delivered/provided, service provider names);
- Whether the problem has improved, resolved or is in need of further monitoring;
- Client input regarding choices and concerns.

J. Signatures

1. The CM and SCM must both sign and date the care plan within two weeks of the last re/assessment. These signatures are required to activate the plan and to initiate purchases with waiver funds.

2. The client's signature* must be obtained within 90 days of care plan activation. The client's signature indicates their acceptance of the plan but is not required prior to the commencement of any services. Note: Pending receipt of the client's signature on the care plan the Progress Notes must reflect discussion of the Care Plan and the client's acceptance pending review and signature.

3. The care plan must be rewritten annually. Requirements for new signatures (CM, SCM, and client) follow the parameters described above.

*Client's signature: for a client who is unable to sign, the signature may be provided by their conservator, agent, or personal representative (Section 3.640.4 Care Plan Activation: Signatures and Review Process; Section 5.810 Staff Signatures and Signature Requirements).